CAP
Center for Aging Policy

ADVOCACY ALERT

n4a.
Advocacy. Action. Answers on Aging.

JULY 1, 2003

SEPARATE HOUSE AND SENATE PRESCRIPTION DRUG BILLS GO TO CONFERENCE AFTER 4th OF JULY RECESS

USE THE ATTACHED n4a/CAP TALKING POINTS TO EXPRESS CONCERNS ABOUT THE MEASURES TO YOUR LEGISLATORS

As you are probably aware, late last week the House and Senate passed separate bills that would add a prescription drug benefit to the Medicare program. When Congress reconvenes after the July 4th Recess select members of the House and Senate will be appointed to a "conference committee" to resolve the differences in the two bills and develop a unified measure that both chambers would then have to pass.

Both the House and Senate bills fall short on providing meaningful relief to Medicare beneficiaries from prescription drug expenses, but there is opportunity while the bills are "in conference" to improve the legislation. n4a and CAP developed the attached talking to highlight some of the concerns with both the House and Senate plans.

WHAT YOU CAN DO:

Your legislators are home for the 4th of July Recess. Use this opportunity to talk with your legislators about the concerns you have with the prescription drug bills that recently passed in the House and Senate and the changes you hope will occur when the differences in the bills are resolved in conference. Feel free to use the attached talking points to highlight how specific provisions in the bills fall short of providing a meaningful benefit.

N4A/CAP TALKING POINTS

MAJOR CONCERNS WITH SENATE AND HOUSE PRESCRIPTION DRUG BENEFIT BILLS

July 1, 2003

RELIANCE ON PRIVATE PLANS

Although the bills are said to be traditional fee-for-service Medicare, under both the House and Senate versions, beneficiaries would actually receive benefits through private plans. Two private insurance companies would be selected to provide prescription benefits in each region, which would have great latitude over establishing the amount of premiums, the benefit structure and where beneficiaries would go to receive prescription drugs.

Private plans are not available in every part of the country, and vary considerably from state to state. According to a report published by Families USA, 80.2% of rural Medicare beneficiaries (9.3 million) live in counties that currently have no private plan, and many others live in rural areas where only one private plan exists.

Under the House plan if no drug benefit only private plan enters the market there is no requirement for a government "fall-back" to provide the benefit. An individual is considered to have access to coverage as long as a private HMO or PPO is offering a drug benefit as part of their package.

LIMITATIONS IN COVERAGE:

Neither the House or Senate prescription drug plans are as generous as seniors might be expecting. If an individual is low-income and does not have many assets or if they have very high out-of-pocket (catastrophic) costs, they will benefit the most from the bills. However, if an individual's income is over about $14,000 and they have out-of-pocket costs of less than approximately $1,200 in the Senate and $800 in the House (the break-even point), they would not realize any benefits.

Kaiser Family Foundation has provided this website for individuals to calculate how beneficial both the House and Senate plans would be to them based on their annual drug costs: **http://www.kaisernetwork.org/drugcalculator**

COVERAGE GAPS:

Under the Senate proposal, after a $275 deductible, with monthly premiums about $35, the individual will receive a 50% co-pay on all medication until they have incurred $4,500 in prescription drug expenses. At that point the individual continues to pay their monthly premium and has to pay 100% of prescription drug costs until he/she has reached expenses totaling $5,800, at which point the beneficiary only has a 10% co-pay on all additional prescription drug cost that year.

Under the House plan an individual, after paying a $250 deductible, and meeting a monthly premium of about $35, receives an 80% co-pay 50% co-pay on all medication until an individual has reached $4,500 in prescription drug expenses. At that point the individual continues to pay their monthly premium and has to pay 100% of prescription drug costs until he/she has reached expenses totaling $5,800, at which point the beneficiary only has a 10% co-pay on all additional prescription drug cost that year.

LOW-INCOME PROTECTIONS REQUIRE AN ASSET TEST:

The low-income protections in the House and Senate bills require that individuals seeking such protections undergo an asset test. The Senate bill is more generous than the House -- the Senate would allow $10,000 for an individual and $20,000 for a couple – the House would allow $6,000 for individuals and $9,000 for a couple. This could penalize many older people who have saved their entire lives, in part to support health care costs in their later years.

FLUCTUATING PREMIUM COSTS:

Because the benefit in both the House and Senate proposals are based on private plans, there is considerable leeway given to the insurer in the premium, formularies they establish. Private plans only have to guarantee two years of coverage and after that are free to drop coverage, leaving beneficiaries scrambling to obtain coverage elsewhere.

While both the House and Senate plans include a proposed “average” premium of $35, in actuality private insurers could set the premium at whatever price they determine, as long as the benefit meets an “actuarial value” of a standard coverage plan. Currently HMO premiums for existing drug benefits range from $99 to $16

LACK OF UNIVERSAL COVERAGE:

Currently all Medicare enrollees, regardless of income, are eligible for all the benefits the program offers. Both the House and Senate proposals would change that.

- The Senate proposal excludes individuals who are “dually eligibly” from receiving the new Medicare prescription drug benefit. State Medicaid programs, which differ considerably in coverage and benefit, would be responsible for providing drug coverage, an optional Medicaid benefit, to low income Medicare beneficiaries eligible for Medicaid.

- The House proposal includes a provision whereby the benefit for catastrophic coverage is based on an individual’s income, creating a dangerous precedent that puts at risk the universality of Medicare as a defined benefit for all eligible individuals.

- The House plan requires traditional fee-for-service providers to competitively bid for Medicare patients in 2010. Managed-care plans have historically attracted healthier individuals. With healthier individuals opting for the less costly private plans, adverse selection will prevail in fee-for-service and premiums for sicker, older individuals who remain in fee-for-service will increase significantly.

LACK OF MEANINGFUL COST CONTROLS:

Neither the House nor the Senate plan includes any comprehensive provisions to hold down the prices of prescription drugs. Because the benefit is delivered through a variety of private market plans, the group purchasing power of 40 million beneficiaries is eroded.

Although both plans include provisions to try to make lower-price generic drugs more available, the Senate measure would allow the reimportation of medicines back from Canada subject to the Administration's approval. Both bills side-step the critical issue of making prescription drugs more affordable to seniors and people with disabilities.

OTHER CONCERNS:

- The benefit (other than a prescription drug card) would be delayed until 2006.
- There would be an increase in out-of-pocket expenses in other parts of Medicare. The Part B outpatient deductible would increase from $100-125 and then be adjusted annually for inflation.
- Employers would likely reduce retiree prescription drug benefits and current retirees could lose employer-based coverage, which in some cases is considerably better than the current House and Senate plans. The Congressional budget office estimates that from 35-37% of beneficiaries currently receiving prescription drug coverage through employers would lose that coverage.

If you have any questions: Shawn McDermott at SMcDermott@n4a.org or 202.296.8130.